



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UNIVERSITY HEALTH SYSTEM
4502 MEDICAL DRIVE
SAN ANTONIO TX 78229-4493

Respondent Name

Service Lloyds Insurance Co

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-1167-01

MFDR Date Received

December 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DENIED-NON NETWORK PROVIDER"

Amount in Dispute: \$230.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Respondent seeks a finding that Requestor is due no reimbursement the Provider failed to obtain approval to treat Claimant out of network."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Suite 100, Austin, Texas 78735

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2011	Outpatient Hospital Services	\$230.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §413.0115, Voluntary or Involuntary Networks.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 7, 2011

- 196 – Non Network Provider
- B5 – Pymnt Adj/Program guidelines not met or exceeded
- TC – Technical Component

Explanation of benefits dated April 11, 2011

- 193 – Original payment decision maintained

- 196 – Non Network Provider
- B5 – Pymnt Adj/Program guidelines not met or exceeded
- TC – Technical Component

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. §133.305 (a)(4) defines a medical fee dispute as “A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee’s compensable injury.” Non-network health care is defined in Section (a) (5) of the same rule as “Health care not [emphasis added] delivered, or arranged by a certified workers’ compensation health care network as defined in Insurance Code Chapter 1305 and related rules...” 28 Tex. Admin. Code §133.307 (a) (1) similarly states that “This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care...” Therefore, the division’s medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.
2. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may not be resolved pursuant to 28 Tex. Admin. Code §133.307; for that reason, no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 13, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.